CITY OF LINCOLN NEBRASKA

2024

Benefits Guide

January 1 - December 31, 2024

Welcome

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

When Coverage Begins

- **New Hires:** You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following date of hire.
  If you fail to enroll on time, you will **NOT** have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1 - December 31, 2024.

Choose Carefully!

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse or child
- You lose coverage under your spouse's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 30 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

Required Information—*You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.*

Inside

Enrollment

Changes must be made through Oracle. There, you will find detailed information about the plans available to you and instructions for enrolling.

Medical

We are proud to provide comprehensive medical and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Following is a brief description of each plan.

Aetna PPO

These plans give you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

- The plan pays the full cost of qualified in-network preventive health care services.
- You pay the full cost of non-preventive health care services until you meet the **annual deductible**. You may also have to pay a fixed dollar amount (**copay**) for certain services. ***NOTE**: If you enroll one or more family members, each covered family member is only required to meet the INDIVIDUAL deductible (up to the family limit) before the plan starts to pay expenses for that individual.*
- Once you meet the deductible, you pay a percentage of certain health care expenses (**coinsurance**) and the plan pays the rest.
- Once your deductible, copays and coinsurance add up to the **out-of-pocket maximum**, the plan pays the full cost of all qualified health care services for the rest of the year.

The following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Medical Benefits	Aetna $300 PPO - IAFF		Aetna $400 PPO - LPU		Aetna $400 PPO - PAGE, M&W, ATU, E, DSS, X, LCEA	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per calendar year)						
Individual / Embedded Family	$300 / $600	$300 / $600	$400 / $800	$800 / $1,600	$400 / $800	$800 / $1,600
Out-of-Pocket Maximum (per calendar year; includes Deductible, Coinsurance, and Medical/Rx copays)						
Individual / Family	$800 / $1,600	$1,550 / $3,100	$1,400 / $2,300	$2,800 / $4,600	$2,100 / $4,200	$3,100 / $6,200
Covered Services						
Office Visits (physician/specialist)	$20 copay	20%*	$25 copay	30%*	$25 copay	30%*
Virtual Visits	$20 copay	Not covered	$25 copay	Not covered	$25 copay	Not covered
Routine Preventive Care	No charge	20%*	No charge	30%*	No charge	30%*
Outpatient Diagnostic (lab/X-ray)	No charge	20%*	No charge	30%*	No charge	30%*
Complex Imaging	No charge	20%*	No charge	30%*	No charge	30%*
Chiropractic Services	$20 copay	20%*	$25 copay	30%*	$25 copay	30%*
Ambulance	10%*		20%*		20%*	20%*
Emergency Room	$150 copay		$150 copay, then 20%*	$150 copay, then 20%*	$150 copay, then 20%*	$150 copay, then 20%*
Urgent Care Facility	$35 copay	20%*	$35 copay	30%*	$40 copay	30%*
Inpatient Hospital Stay	$100 copay then 10%*	$100 copay then 20%*	$100 copay, then 20%*	$100 copay, then 30%*	$100 copay, then 20%*	$100 copay, then 30%*
Outpatient Surgery	10%*	20%*	20%*	30%*	20%*	30%*
Prescription Drugs						
Pharmacy Deductible (Individual / Family)	-		-		$3,000 / $6,000	
Retail Pharmacy (30-day supply) Generic Preferred Brand Name Non-Preferred Brand Name	$10 $25 $50	In-Network copays + 25% penalty	$10 $25 $50	In-Network copays + 25% penalty	min. $5 / max. $25 min. $25 / max. $50 min. $50 / max. $75	In-Network copays + 25% penalty
Mail Order (90-day supply) Generic Preferred Brand Name Non-Preferred Brand Name	$20 $50 $100	N/A	$20 $50 $100	N/A	min. $10 / max. $50 min. $50 / max. $100 min. $100 / max. $150	N/A

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying. *Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay. 1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount. 2. If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.

Medical

KEY TERMS TO REMEMBER

ANNUAL DEDUCTIBLE

The amount you must pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

OUT-OF-POCKET MAXIMUM

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays and coinsurance.

COPAYS AND COINSURANCE

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the provider.

PLAN TYPES

- PPO – A network of doctors, hospitals and other health care providers

IN NETWORK VS. OUT OF NETWORK

In-network health care providers have agreed to accept certain rates, so you will typically pay less when you use them. Out-of-network health care providers can charge you any amount they want. Because there is no negotiated rate, these services usually cost you more.

PREMIUMS

A premium is the money that is automatically taken out of your paycheck for health insurance. In addition to the premium, you also pay additional amounts for health care when you use it, such as a deductible, copayment, and coinsurance.

Things to Know About Insurance (cont'd)

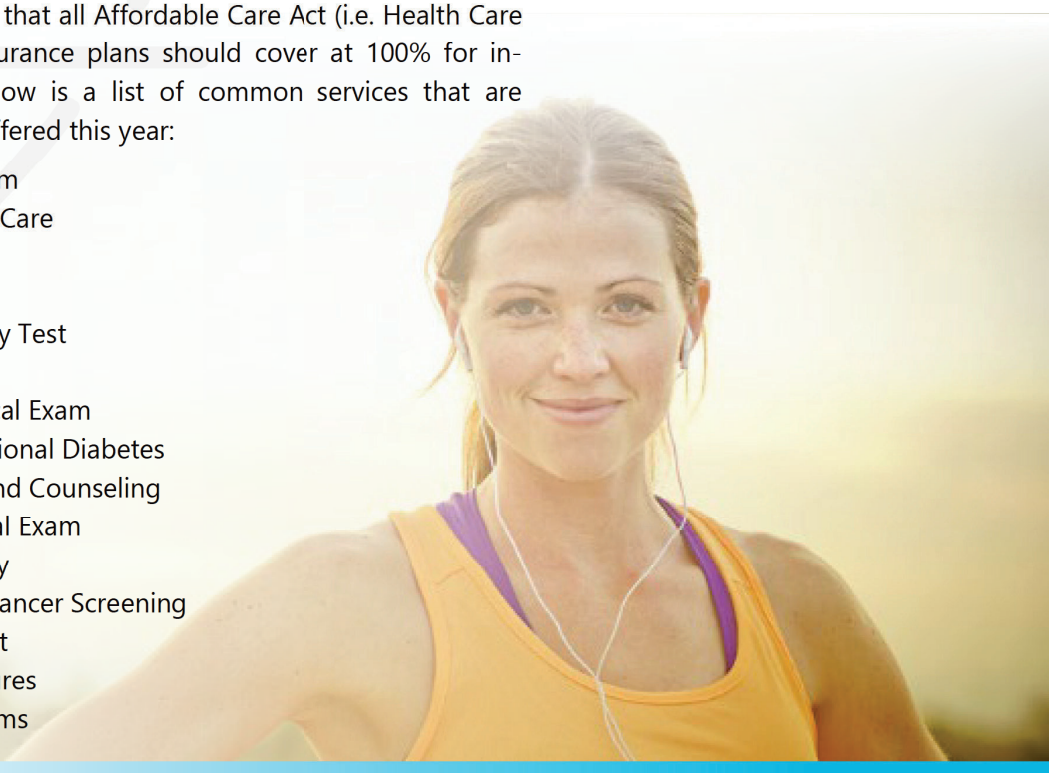
Medical

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations. Through the plans offered by City of Lincoln, all covered individuals and family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**

WHICH PREVENTIVE CARE SERVICES ARE COVERED?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence



"An ounce of prevention is worth a pound of cure"

Medical Resources

Why not make sure you are fully utilizing your health care benefits? You can count on Aetna's advocacy services to help navigate across the entire spectrum of health and wellness. From dealing with a significant medical diagnosis to resolving complex claim issues to mapping out a path for improving health, Aetna advocates are here for you and your family.

Personalized nurse support
Our clinical nurses can collaborate with service teams to help you achieve your health goals. Our nurses are supported with a multidisciplinary team that can help guide you to local resources. Whether you're struggling with emotional issues or an advanced illness, we'll work with you and your family to provide guidance and support.

Local support
With CVS® HealthHUB™ and MinuteClinic® locations inside select CVS Pharmacy® and Target® stores, you have a broad range of services to keep you and your family healthy.

Tools, tips and support centers
Through your Aetna® member website, you'll be able to locate a doctor, review your benefits information and watch informational health videos. And for specific health needs, you can explore member resources like the Cancer Support Center, the Maternity Support Center and the Back and Joint Care Support Center.

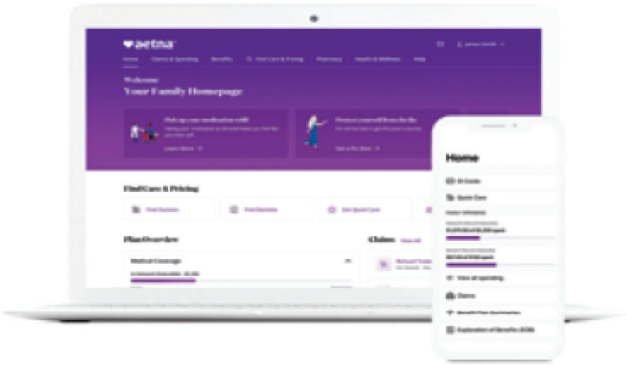
Access to information — whenever, wherever
Always on the go? No problem. Your member website is fully mobile. Remember, this is your one-stop shop for getting the help you need. And when you download the Aetna Health℠ app, you can access it all from the palm of your hand.

Get started with these resources today.
Go to **Aetna.com** to log in to your member website.

Medical Resources

Aetna® member website and Aetna Health℠ app

Manage your benefits, connect to care, handle claims — from anywhere.



As a member, you can:

- ✓ View your health plan summary and get information about what's covered
- ✓ Track spending and progress toward your deductible for you and your family
- ✓ View and pay claims, even see the breakdown of your costs, like what's covered by your plan and what you're responsible for
- ✓ Use tools to help you choose quality in-network providers including those offering telemedicine services
- ✓ Estimate and compare costs
- ✓ Get personalized reminders to help improve your health

Once you're a member, here's how you can connect:

Your Aetna member website

Go to Aetna.com to create an account and log in to your member website.

The Aetna Health app

Get the Aetna Health app by texting "GETAPP" to 90156 for a link to download the app and create an account. Message and data rates may apply.*

Available on the App Store | GET IT ON Google Play

Medical Resources

made available through aetna™

TELADOC.

Access to quality care at your fingertips

General Medical
$49 or less/visit

Talk to a licensed doctor for non-emergency conditions 24/7
Flu • Sinus infections • Sore throats • And more

Mental Health
$85 or less/therapist visit
$190 or less/psychiatrist first visit
$95/psychiatrist ongoing visit

Talk to a therapist 7 days a week (7 a.m. to 9 p.m. local time)

Dermatology
$75 or less/consult

Upload images of a skin issue online and get a custom treatment plan within 2 days
Eczema • Acne • Rashes • And more

Set up your account or log in today.

Teladoc.com/Aetna | 1-855-Teladoc (835-2362)

*Effective September 1, 2022, members may be charged a *$50 fee for no-shows and cancellations within 24 hours of a scheduled Mental Health visit. This practice is consistent with other telehealth providers as well as brick and mortar providers who charge late cancellation and no-show fees. We recognize that this is a new policy, and we will waive the fee related to a member's first late cancellation or no-show

Dental

We are proud to offer you an Ameritas dental plan.

Ameritas DPPO

This plan offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Ameritas network.

The following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Dental Benefits	Ameritas DPPO	
	In-Network	Out-of-Network[1]
Deductible (per calendar year)		
Individual / Family	$25 / $75	$50 / $150
Benefit Maximum (per calendar year; basic and major services combined)		
Per Individual	$2,000	$2,000
Covered Services		
Preventive Services	No charge	No charge
Basic Services	20%*	20%*
Major Services	20%*	50%*
Orthodontia (Child & Adult)	50%* up to a $2,000 annual maximum per person	50%* up to a $2,000 annual maximum per person

Coinsurance percentages shown in the above chart represent what the member is responsible for paying.

***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Vision

We are proud to offer you a vision plan by EyeMed administered by Ameritas.

Ameritas (EyeMed)

This plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the Ameritas (EyeMed) network.

The following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Vision Benefits	Ameritas (EyeMed)	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10 copay	Up to $35
Lenses (once every 12 months)	$0 copay, then covered in full	
Single Vision		Up to $25
Bifocal		Up to $40
Trifocal		Up to $55
Frames (once every 12 months)	$100 plus 20% off the balance	Up to $45
Contact Lenses (once every 12 months (in lieu of spectacle lenses and frames))	Elective: $0 copay, $115 allowance, 15% off the balance Medically Necessary: Paid in full Contact Lens Fit & Follow-up: Standard-Reimbursed up to $55 Premium: 10% off retail price	Elective: Up to $100 Medically Necessary: Up to $200 Contact Lens Fit & Follow-up: N/A

Things to Know About Insurance (cont'd)

Dental

Ameritas

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

In Network

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Sealants (age 16 and under)	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Amalgams	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Restorative Composites	• Crown Repair
• Periapical X-rays	• Endodontics (nonsurgical)	• Implants
• Cleaning (2 per benefit period)	• Endodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Fluoride for Children 18 and under (1 per benefit period)	• Periodontics (nonsurgical)	
• Space Maintainers	• Periodontics (surgical)	
	• Denture Repair	
	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

Out of Network

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Sealants (age 16 and under)	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Amalgams	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Restorative Composites	• Crown Repair
• Periapical X-rays	• Endodontics (nonsurgical)	• Implants
• Cleaning (2 per benefit period)	• Endodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Fluoride for Children 18 and under (1 per benefit period)	• Periodontics (nonsurgical)	
• Space Maintainers	• Periodontics (surgical)	
	• Denture Repair	
	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER**, then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at 800-487-5553 or www.ameritas.com/olbc/cityoflincoln there is a link on the right hand side or use https://dentalnetwork.ameritas.com

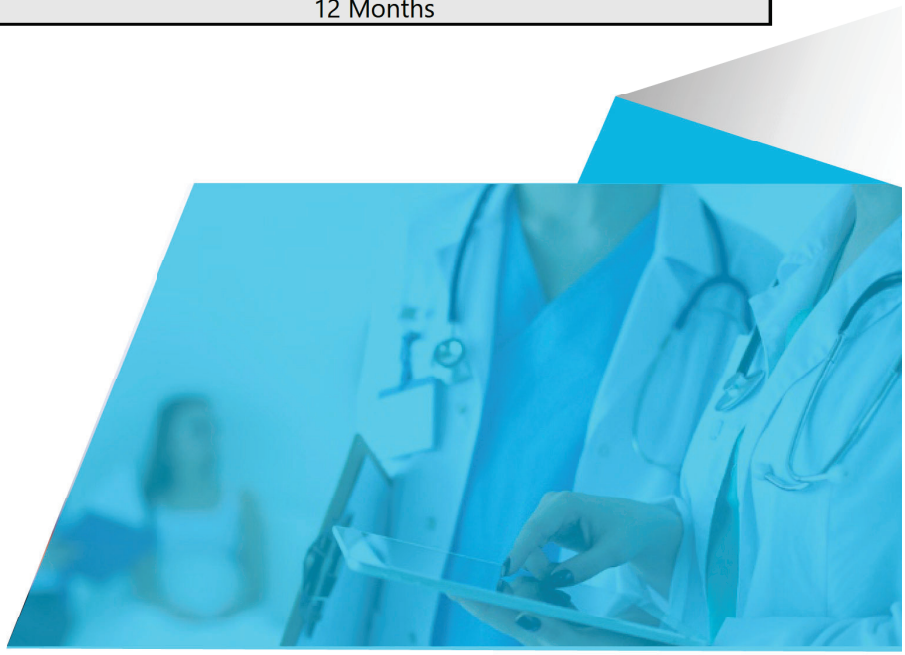
Things to Know About Insurance (cont'd)

Vision

Ameritas

SUMMARY OF COVERAGE

Plan Features		
	IN NETWORK	**OUT OF NETWORK**
Vision Exam	100% after $10 copay	Up to $35
Lenses		
Single	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to 55
Lenticular	20% discount	No Benefit
Frames	$100	Up to $45
Contacts (Fit & Follow Up Exams)	**Standard**: Up to $55 **Premium:** 10% off of retail	Not Covered
Elective Contacts	Up to $115	Up to $100
Necessary Contacts in Lieu of Eyeglasses	Covered in full	Up to $200
Frequency (Months)		
Exam	12 Months	
Lenses	12 Months	
Frames	12 Months	
Contacts	12 Months	



Things to Know About Insurance (cont'd)

Vision

Ameritas

Additional ViewPointe® H Features

EyeMed In-Network Discounts	15% discount off the remaining balance in excess of the conventional contact lens allowance. 20% discount off the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.
EyeMed In-Network Secondary Purchase Plan	Members receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Members receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit EyeMedvisioncare.com for details.

Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed network provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866-289-0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com
View plan benefit information at: eyemedvisioncare.com

Flexible Spending Accounts

We provide you with an opportunity to participate in our flexible spending accounts (FSAs) administered by Navia Benefit Solutions. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

Health Care FSA

For 2024, you may contribute up to $3,050 to cover qualified health care expenses incurred by you, your spouse and your children up to age 26. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions and Over-the-Counter Drugs
- Menstrual Care Products
- Dental Treatment
- Orthodontia
- Eye Exams, Materials, LASIK

Dependent Care FSA

For 2024, you may contribute up to $5,000 (per family) to cover eligible dependent care expenses ($2,500 if you and your spouse file separate tax returns) for the care of a dependent while you are actively at work. Some eligible expenses include:

- Care of a dependent child under the age of 13 by before and after school programs, nursery schools, pre-school or daycare centers
- Care of a household member who is physically or mentally incapable of caring for themselves and qualifies as your federal tax dependent

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p503.pdf**.**

Commuter Benefits

Commuter Benefits administered through Navia Benefit Solutions enables you to set aside money in up to two accounts to pay for qualified work-related parking expenses on a pre-tax basis — reducing your taxable income. Your contributions are deducted from your paycheck each pay period. For January 1 - December 31, 2024, you may contribute up to $500 per month into each account (transit and parking) . This amount may change annually, per IRS regulations. Exclusions apply. See plan document for details and exclusions.

FSA Rules

YOU MUST ENROLL EACH YEAR TO PARTICIPATE.

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

Unused funds will **NOT** be returned to you or carried over to the following year.

Employees have until 03/15/2025 to use their 2024 FSA funds for new expenses.

Claims filing deadline for the FSA and Parking benefits is 03/29/2025.

The IRS and your employer establish the maximum amount you may contribute each year. See the plan documents for details.

Flexible Spending Accounts

navia benefit solutions

A Healthcare FSA is a personal expense account that works with your employer's health plan, allowing you to set aside a portion of your salary pre-tax to pay for qualified medical expenses.

Many ways to use your dollars

Use it for eligible medical, dental, vision, feminine products, over-the-counter and prescription drugs. In fact, there are more than 38,000 ways you can use your FSA funds.

Family coverage

It covers you, your spouse, and eligible dependents!

Easy to use

Pay using your Navia debit card or by submitting a claim online or on the Navia mobile app.

Maximum Contribution

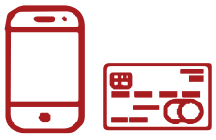
IMPORTANT! The contribution limit varies by employer, but you may be able to contribute up to $3050 per year. The funds in the account must be used during the plan year, but they are available to you immediately.

FAMILY

COVERS YOUR WHOLE FAMILY

38K

DIFFERENT WAYS TO USE YOUR FUNDS



EASY

MULTIPLE WAYS TO SUBMIT CLAIMS

$3050

MAXIMUM CONTRIBUTION

Dependent Flexible Spending Accounts

navia benefit solutions

A Day Care FSA is a pre-tax benefit account that enables you to set aside money to pay for your out-of-pocket daycare or dependent care expenses.

Save on day care expenses you already pay for
This FSA covers child care for dependents up to age 12 and dependents who cannot care for themselves while you're working.

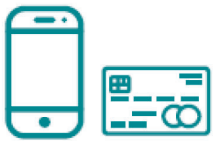
Pay your provider or a family member for child care
With a Day Care FSA, participants can use their account to pay your licensed day care provider for child care services. You can also use your Day Care FSA to pay a family member to watch your child, as long as the family member is not your spouse and age 19 or older.

Easy to use
Pay using your Navia debit card or by submitting a claim online or on the Navia mobile app.

Maximum contribution
The contribution limit varies by employer, but you may be able to contribute up to $5000 per year. The funds in the account must be used during the plan year. Much like your banking account, you cannot spend more than what is in your account each month.

SAVE
USE FUNDS TO PAY YOUR PROVIDER OR FAMILY MEMBER

CARE
CHILDREN AND ELDERS COVERED



EASY
MULTIPLE WAYS TO SUBMIT CLAIMS

$5000
MAXIMUM CONTRIBUTION

Life and AD&D – The Hartford

Life insurance provides your named beneficiary(ies) with a benefit after your death.

Accidental death and dismemberment (AD&D) insurance provides specified benefits to you in the event of an accident that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the life and the AD&D benefit would be payable.

Basic Life/AD&D (Company-paid)

This benefit is provided at NO COST to you through Hartford.

	Benefit Amount
Employee	Class 1 – All Admin Assistants to the Mayor and Mayor: $50,000
	Class 2 – All LCEA and 'E' Employees not subject to a CBA: $70,000
	Class 3 –All ATU Employees of the City: $50,000
	Class 4 –All Police of the City: $75,000
	Class 5 –All PAGE Employees and 'X' Employees of the City not subject to a CBA: $71,000
	Class 6 –All 'M&W' Employees of the City not subject to a CBA: $70,000
	Class 7 – All Firefighters of the City: $75,000
	Class 8 –All Directors: $70,000

Supplemental Life/AD&D (Employee-paid)

If you determine you need more than the basic coverage, you may purchase additional coverage through Hartford for yourself and your eligible family members.

	Benefit Option	Guaranteed Issue[1]
Employee	$10,000 increments; maximum of the Lesser of 5x annual earnings or $500,000	Lesser of 5x annual earnings or $250,000
Spouse	$5,000 increments; maximum of the Lesser of 50% of Employee's Benefit or $100,000	Employee Participation Required; $50,000
Child(ren)	Live Birth to Age 26 - $10,000	Employee Participation Required $10,000

1. During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

Voluntary Benefits

Our benefit plans are here to help you and your family live well—and stay well. But did you know that you can strengthen your coverage even further? It's true! Our voluntary benefits through Allstate Benefits are designed to complement your health care coverage and allow you to customize our benefits to you and your family's needs. The best part? Benefits from these plans are paid directly to you! Coverage is also available for your spouse and dependents. You can enroll in these plans during Open Enrollment—they're completely voluntary, which means you are responsible for paying for coverage at affordable group rates. Rates for the Allstate Benefits coverages can be found by visiting https://lincolngovbenefits.com or by calling the Voluntary Benefits Enrollment Call Center at 877-282-0808.

Disability Income Protector (Short-Term Disability)

If you are deemed disabled, Disability Income Protector offers you a lump sum payment to use as you see fit. This plan does not integrate with any other disability insurance. For additional information on this plan as well as how to enroll, please reach out to your Allstate agent.

Critical Illness

Most of us don't have an extra $7,000 ready to spend—and even if we do, we don't want to spend it on medical expenses. Unfortunately, the average cost to treat a critical illness is just that: $7,000[1]. But with critical illness insurance, you'll receive a lump-sum benefit if you are diagnosed with a covered condition. You can use this benefit however you like, including to help pay for: treatments, prescriptions, travel, increased living expenses and more.

Accident Insurance

Accident insurance can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: You visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But in reality, treating a broken leg can cost up to $7,500[2]. And it's not only broken limbs—an average non-fatal injury could cost you $6,620 in medical bills[3]. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

1. MetLife Accident and Critical Illness Impact Study.
1. Why health insurance is important: Protection from high medical costs. HealthCare.gov
2. Average medical cost of fatal and non-fatal injuries by type in the USA, December 2019. National Library of Medicine.

Employee Assistance Program (EAP)

Life is full of challenges, and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The EAP is provided at **NO COST** to you through Contiuum EAP.

The EAP can help with the following issues, among others:

- Mental health
- Relationships or marital conflicts
- Child and eldercare
- Substance abuse
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- 1-5 in-person sessions with a counselor per issue, per year, per individual
- Unlimited toll-free phone access and online resources

Critical Illness

Allstate Benefits

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels.

The treatment to recovery is vital, but it can also be expensive. Your medical coverage may only cover some of the costs associated with treatment. You're still responsible for deductibles and coinsurance. If treatment keeps you out of work, the financial worries can grow quickly and stress levels may rise.

Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness. With the expense of treatment often high, seeking the treatment you need could seem like a financial burden. When a diagnosis occurs, you need to be focused on getting better and taking control of your health, not stressing over financial worries.

Here's How It Works

You choose benefits to protect yourself and any family members if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

Meeting Your Needs

- Guaranteed Issue, meaning no medical questions to answer at initial enrollment
- Coverage available for dependents
- Covered dependents receive 50% of your Basic-Benefit Amount
- Benefits paid regardless of any other medical or disability plan coverage
- Premiums are affordable and conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details
- 25% of your Basic-Benefit Amount is paid for Advanced Alzheimer's Disease and Advanced Parkinson's Disease

With Allstate Benefits, you can make treatment decisions without putting your finances at risk. **Are you in Good Hands? You can be.**

BENEFIT AMOUNTS

†Covered dependents receive 50% of your benefit amount

INITIAL CRITICAL ILLNESS BENEFITS†	PLAN 1	PLAN 2
Heart Attack (100%)	$15,000	$30,000
Stroke (100%)	$15,000	$30,000
Major Organ Transplant (100%)	$15,000	$30,000
End Stage Renal Failure (100%)	$15,000	$30,000
Coronary Artery Bypass Surgery (25%)	$3,750	$7,500
Waiver of Premium (employee only)	Yes	Yes
CANCER CRITICAL ILLNESS BENEFITS†	**PLAN 1**	**PLAN 2**
Invasive Cancer (100%)	$15,000	$30,000
Carcinoma in Situ (25%)	$3,750	$7,500
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS II†	**PLAN 1**	**PLAN 2**
Advanced Alzheimer's Disease (25%)	$3,750	$7,500
Advanced Parkinson's Disease (25%)	$3,750	$7,500
Benign Brain Tumor (100%)	$15,000	$30,000
Coma (100%)	$15,000	$30,000
Complete Blindness (100%)	$15,000	$30,000
Complete Loss of Hearing (100%)	$15,000	$30,000
Paralysis (100%)	$15,000	$30,000
OPTIONAL/ADDITIONAL BENEFIT	**PLAN 1**	**PLAN 2**
Wellness Benefit (per year)	$50	$50

Accident Insurance

Allstate Benefits

Today, active lifestyles in or out of the home may result in bumps, bruises and sometimes breaks. Getting the right treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly.

Most major medical insurance plans only pay a portion of the bills. Our coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses.

With Accident insurance from Allstate Benefits, you can gain the advantage of financial support, thanks to the cash benefits paid directly to you. You also gain the financial empowerment to seek the treatment needed to be on the mend.

Here's How It Works

Our coverage pays you cash benefits that correspond with hospital and intensive care confinement. Your plan may also include coverage for a variety of occurrences, such as: dismemberment; dislocation or fracture; ambulance services; physical therapy and more. The cash benefits can be used to help pay for deductibles, treatment, rent and more.

Meeting Your Needs

- Guaranteed Issue, meaning no medical questions to answer
- Benefits are paid directly to you unless otherwise assigned
- Pays in addition to other insurance coverage
- Coverage also available for your dependents
- Premiums are affordable and can be conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details

With Allstate Benefits, you can protect your finances against life's slips and falls.
Are you in Good Hands? You can be.

Disability

Like most, unless you know someone who has been disabled, you may not see the value of Disability insurance. You may think it won't happen to you, but if it does, you are vulnerable to lost income.

An injury or sickness may slow you down, but it won't slow down your monthly bills. Expenses such as house and car payments, or even daily living expenses such as groceries and gas, will still need to be paid. Disability insurance can help replace your lost income and help ensure your finances are not depleted.

Here's How It Works

You choose the maximum monthly benefit level that meets your needs. Then, if you are faced with a period of unexpected sickness or off-the-job injury, you will receive cash benefits to use as you see fit. This could include medical treatments, daily living expenses and more.

Meeting Your Needs

- You choose the monthly maximum benefit level that meets your needs
- Benefits start the first day after the elimination (waiting) period, when you are totally disabled and cannot work
- Premiums are affordable and conveniently payroll deducted
- You can take your coverage with you if you leave your job or your employer cancels coverage; refer to your certificate for details

With Allstate Benefits, you gain the power to make treatment decisions without putting your finances at risk. **Are you in Good Hands? You can be.**

DETAILS OF COVERAGE

Maximum Monthly Benefit - $5000
Maximum Benefit Period - 6 months
Elimination Period for Accident - 14 Days
Elimination Period for Sickness - 14 Days

Cost of Benefits

January 1 - December 31, 2024

Your contributions toward the cost of benefits are automatically deducted from your paycheck before taxes. As the cost of health insurance continues to rise, City of Lincoln is continuously looking for ways to keep their benefits package competitive and affordable for everyone. We have been fortunate over the last several years to keep employee costs the same, while most organizations have been forced to increase premiums on an annual basis over that same timeframe. This year, there will be an increase to your medical plan premiums which are outlined below. We will continue to look for ways to mitigate healthcare plan costs and keep premiums as low as possible for everyone involved.

Medical

Coverage Tier	Per Paycheck Employee Contribution (24 Deductions per Year)					
	IAFF	LPU	ATU	PAGE, Excluded X	Mayor, Excluded W, Directors, LMCEA	Excluded E, LCEA
Employee Only	$19.32	$37.73	$34.62	$34.61	$38.94	$43.27
Employee + Spouse	$63.49	$162.69	$148.30	$98.87	$108.75	$138.41
Employee + Child(ren)	$51.48	$127.32	$120.24	$80.16	$88.18	$112.23
Family	$85.23	$207.94	$190.80	$127.20	$139.92	$178.08

Dental

Coverage Tier	Per Paycheck Employee Contribution (24 Deductions per Year)				
	IAFF	LPU	ATU, PAGE, Excluded X	Mayor, Excluded W, Directors, LMCEA	Excluded E, LCEA
Employee Only	$0.00	$0.00	$9.82	$0.39	$0.39
Employee + Spouse	$2.59	$14.70	$21.62	$14.06	$16.00
Employee + Child(ren)	$2.12	$12.03	$17.69	$11.49	$13.09
Family	$3.80	$21.50	$31.62	$20.55	$23.40

Vision

In-Network	Per Paycheck Employee Contribution (24 Deductions per Year)		
	IAFF	LPU	ATU, PAGE, LCEA, M&W, E, X, DSS
Employee Only	$4.58	$4.58	$4,58
Employee + Spouse	$8.70	$8.70	$8.70
Employee + Child(ren)	$9.16	$9.16	$9.16
Family	$13.64	$13.64	$13.64

Cost of Benefits (cont'd)

Supplemental Life/AD&D

Employee/Spouse Age Range	Per Paycheck Employee Contribution (24 per Year) Vol. Life and AD&D Premium Rates per $1,000
Under 30	$0.032
30-34	$0.036
35-39	$0.050
40-44	$0.072
45-49	$0.117
50-54	$0.198
55-59	$0.306
60-64	$0.464
65-69	$0.851
70-74	$1.485
75+	$2.453
AD&D Rates applies to employee, spouse and child life	$0.02
Child life ($10,000 Benefit)	$0.69 Flat Rate

Contact Information

Coverage	Carrier	Phone #	Website/Email
Medical	Aetna	(866) 290-3711	www.aetna.com
Dental	Ameritas	(800) 487-5553	https://dentalnetwork.ameritas.com
Vision	Ameritas (EyeMed)	(866) 289-0614	www.ameritas.com www.eyemedvisioncare.com
Flexible Spending Accounts (FSAs)	Navia Benefits	(425) 452-3500 / (800) 669-3539	www.naviabenefits.com customerservice@naviabenefits.com
Life/AD&D	The Hartford	(800) 523-2233	www.thehartford.com
Employee Assistance Program (EAP)	Contiuum EAP	(402) 476-0186 / (800) 755-7636	4continuum.com
Critical Illness / Accident / Disability	Allstate Benefits	(877) 282-0808	www.allstateatwork.com / https://lincolngovbenefits.com/

Questions?

If you have additional questions, you may also contact:

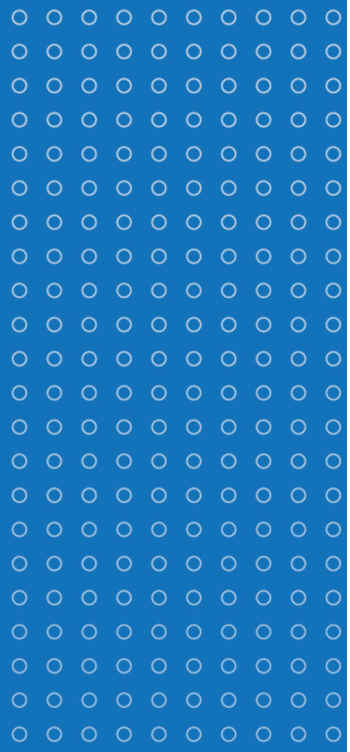
HR Benefits
(402) 441-7597 Option 2
HRBenefits@lincoln.ne.gov

https://www.lincoln.ne.gov/City/Departments/HR/Benefits/City-of-Lincoln-Benefits

Employee Benefits Notices

Annual, New Hire, and Other Notices

Please note: While HUB is providing these notices as a courtesy to its clients, HUB does not provide legal or tax advice. HUB makes no representation or warranty as to the accuracy or completeness of these documents and is not obligated to update them. Consult your attorney and/or professional advisor as to your organization's specific circumstances and legal, tax or other requirements.



HUB

Medicare Part D Creditable Coverage Notice

Important Notice from The City of Lincoln About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Lincoln (the "Plan Sponsor") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

(1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

(2) The Plan Sponsor has determined that the prescription drug coverage offered by the City of Lincoln is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore

considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan Sponsor and don’t join a Medicare drug plan within 63

continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan Sponsor changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You"

handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January1,2024
Name of Entity/Sender:	Melissa Zahourek
Contact-Position/Office:	Benefits Manager
Address:	575 S 10th; Suite 4401; Lincoln, NE 68508
Phone Number:	402-441-7597

Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Notice of Availability of HIPAA Notice of Privacy Practices

The City of Lincoln maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than **30 days** after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have **60 days** after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)